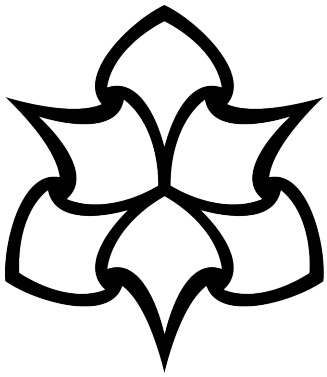

Available Online at: http://webjcli.org/article/view/574/749

A Psycho-Legal Analysis and Criminal Trajectory of Female Child Serial Killer Beverley Allitt

Saskia Ryan[1], Dominic Willmott[1,2], Nicole Sherretts[1] & Krzysztof Kielkiewicz[3]

[1] *Doctoral Researcher, Department of Psychology, University of Huddersfield, Huddersfield, UK*

[2] *Lecturer in Forensic Psychology, School of Social and Health Sciences, Leeds Trinity University, UK*

[3] *Faculty Lecturer, PCI College, Dublin; Department of Psychology, University of Finance and Management, Warsaw*

ABSTRACT

The paper presents a psychological analysis of convicted female serial killer Beverley Allitt with reference to psychopathological and social psychological explanations of her crimes. Whilst cases of female serial homicide such as that of Allitt receive a large amount of attention within popular culture literature, less theorising to date has attempted to psychologically account for her rare form of gendered violence. Although the present exploration provides psychopathological reasoning as the primary explanation for Allitt's crimes, first hand interviews conducted with senior management that worked alongside her at the hospital where she killed are used to argue that the complexities of her behaviour are best understood through the application of varying approaches. The legal implications of her criminality and diagnosis are also discussed. The present analysis therefore offers a unique and contemporary insight into the criminal behaviours of a female child serial killer and impact of such, more broadly, within society.

Key Words: Homicide, Beverley Allitt, Munchausen Syndrome By Proxy, MSBP

INTRODUCTION

In 1992 Beverley Allitt was convicted of four murders, three attempted murders and six counts of grievous bodily harm. Despite this, her name is not widely synonymous with that of other prolific serial killers. In part, this is because the percentage of female serial killers is comparably low to that of male perpetrators (Walters, Drislane, Patrick & Hickey, 2015), despite female violence generally shown to be on the rise (Kamimura, Nourian, Assasnik,

Rathi, & Franchek-Roa, 2016). The nicknames of serial killers are also usually more familiar due to the 'celebritization' and popular culture surrounding this type of crime within society (Jarvis, 2007). The sobriquet 'Angel of Death' therefore may be more recognizable, referring to those who murder individuals under their care (Kelleher & Kelleher, 1998). The trial and subsequent inquest into Allitt's crimes concluded that she was likely to be suffering from Munchausen Syndrome by Proxy (MSBP), a condition where the sufferer fabricates illness in others - typically children (Clothier, MacDonald & Shaw, 1994).

Whilst constituting a form of Child Abuse and Neglect (CAN) it is perhaps the rarest form, with recent research and reviews of CAN and broader maltreatment making little to no mention of such victimisation (Boduszek et al., 2017; Debowska & Boduszek, 2016; Debowska, Boduszek & Willmott, 2017; Debowska, Willmott, Boduszek & Jones, 2017). Interestingly however, despite the apparent distorted cognitions surrounding the desire to harm children and fabricate illness to account for such, MSBP does not exist as a mental disorder. The Diagnostic and Statistical Manual of Mental Disorders [DSM-V] fails to list MSBP as a clinically diagnosable personality or psychiatric disorder (American Psychiatric Association [APA], 2013). Accordingly during her criminal trial the legal defence of diminished responsibility was neither appropriate nor presented (R v Beverly Allitt 1992 [2007] EWHC 2845). She merely plead not guilty to criminal charges before she was subsequently convicted and sentenced to thirteen concurrent terms of life imprisonment.

Whilst full details of Allitt and her crimes have been examined in greater detail elsewhere (Davies, 1993; Ramsland, 2007), the present paper draws upon the most pertinent behaviours and incidents confirmed, in order to allow for thorough psychosocial and legal examination of her criminality. To do so, the authors also draw upon unique access and information gained through first hand interviews conducted with a senior member of staff who held a faculty managerial role, both prior to, and during Allitt's employment on ward 4 at the Grantham and Kesteven Hospital. The location where the majority of her her crimes took place.

BACKGROUND CASE CHARACTERISTICS

Born in 1968 Allitt's life trajectory is anything but typical which makes for particular interest when exploring varying perspectives for understanding how an individual can perpetrate the crimes that she did. The first incidents brought to the attention of senior healthcare staff took place in a nursing home in the locality of her later crimes, and included the smearing of excrement on walls and discovery of faeces being stored in employee fridges (Personal

Communication, 2013). At the time staff were unaware who was responsible and it was only after her subsequent arrest that these behaviours were connected. After applying for a nursing position at the hospital, where it was normal procedure for managers to be present during interview, Allitt was refused a position on the basis of concerns around her suitability for the role. Undeterred she then applied to the paediatrics ward and despite having trained in adult medicine was able to secure a position, convincing those in charge that having always wanted to work with children, she would develop the relevant skills whilst in the role. This was something which the faculty manager interviewed stated was to result in dire consequences for patients under her care (Personal Communication, 2013).

During her employment at the hospital, one of the doctors had become concerned after receiving the blood results of one of Allit's now known victims. Despite the seemingly atypical results, the doctor had initially doubted his diagnostic interpretation. However when consulting with other medical practitioners it was decided that the police were to be called in. The gathering of evidence was to take a considerable amount of time in order to reliably indicate foul play, during which the death of another child had occurred. Based upon a growing suspicion surrounding her behaviour, Allitt was subsequently suspended. Around the same time media attention had intensified and Allitt had moved to live in another city with her partner at the time. Although suspended with suspicion surrounding her possible involvement in tampering with patients' medication, she was not exempt for gaining alternative employment and was recruited as a nurse at another nursing home. It was here that Allitt's behaviour is thought to have spiralled further, becoming seemingly more deviant and less directed towards children.

Confirmed accounts display she would hide knives under pillows and knock walking sticks out of elderly resident's hands, bizarrely claiming such to have been the work of a poltergeist (Ramsland, 2007). Around this time she is also known to have given a child a drink that led to him collapsing, and seen to inject an elderly resident in the care home with a large amount of insulin which she was not prescribed to take (Personal Communication, 2013; Ramsland, 2007). Whilst the combination of such behaviours at this stage can be quite readily explained as mere accidents or mistakes, an emergent pattern in her behaviour is apparent. A pattern somewhat deviant and that appears at odds with the caring nature usually found within those work in the health profession (Repper, 1995).

KIND AND CARING OR COLD AND CALCULATED?

The manipulation that Allitt was able to exert is arguably one of the most pertinent factors in this case. The families of the victims had been so convinced of her innocence that one father

hired a private detective in defence of Allitt and the parents of another made her an official godmother to the child being perpetrated against (Davies, 1993). The staff at the hospital also fell victim to her manipulation and in the aftermath of her conviction, many lost their careers (Personal Communication, 2013; Ramsland, 2007). One of the doctors had been persuaded by Allitt to administer a fatal dose of insulin to a patient, resulting in her death, despite her never having required the medication. One nurse in charge was quoted to have said, 'poor Beverley Allitt had been there on every occasion, she has been a rock' (Davies, 1993:13) with regards to the number of paediatric deaths on the ward that she had been witness to. Significantly, this individual subsequently committed suicide, widely thought to be a direct result of being duped by the perpetrator.

The impact of her actions and ability to manipulate those around her despite her culpability, clearly had far reaching implications. Retrospective accounts of Beverley Allitt's behaviour appear in part to display an existence of core psychopathic features commonly found in forensic and non-forensic populations including; interpersonal manipulation, egocentrism and an apparent lack of empathy (Boduszek & Debowska, 2016; Boduszek, Debowska & Willmott, 2017a; Boduszek, Debowska & Willmott, 2017b; Debowska et al., 2017). Whilst such psychopathic tendencies are often the source of discussion within popular crime literature (Jarvis, 2007), here we draw, firstly, upon psychopathological principles as the likely explanation for the complex trajectory of behaviour that led to her crimes.

PSYCHOPATHOLOGICAL INTERPRETATIONS

Based upon Allitt's label of MSBP and the testimony presented at the public inquiry, explanations of her crimes are largely rooted in psychopathology. Whilst MSBP is not considered to be a clinically diagnosable disorder, the underlying patterns of behaviour denoted to be a '*factitious disorder imposed on another*' or '*factitious disorder by proxy*' are listed as a developing clinical condition within the DSM-V (p.325, American Psychiatric Association, 2013). Within clinical literature, it is argued that MSBP is associated with higher mortality, morbidity, abuse, family disruption, and harm to siblings than other factitious disorders (Davis et al., 1998) and is more typically associated with an individual's own children (Bande & Garcia-Alba, 2008; Bools, Neale & Meadow, 1994; Boyd, Ritchie & Likhari, 2014; Rosenberg, 1987). Although, there is some evidence of MSBP also occurring within intimate partner relationships (Krebs, Bouden, Loo, & Olie, 1996) and in health care workers (Repper, 1995).

It is argued that underdiagnoses results in poor management of the disorder within society and subsequent forensic dilemmas emerge as these unusual but serious pathologies transcend into criminal acts (Bande & Garcia-Alba, 2008). In comparison to other psychiatric disorders, a diagnosis of a factitious disorder is rare (Bass & Halligan, 2014). Allitt was only ascribed the label of suffering from MSBP after being criminally convicted. In fact, in the year following her conviction, her legal counsel, James Hunt QC, called for a medical expert to report on her condition. The defence employed expert, a Professor Roy Meadows, reported her to be exhibiting MSBP characteristics, alongside explicitly engaging in self-harming behaviours within the prison estate since her conviction. She was deemed to be putting her life and that of other inmates at risk (Ramsland, 2007). Accordingly, on the 5th June 1993 the Home Secretary gave a direction under section 27 of the Mental Health Act 1983 for Beverley Allitt to be moved from HMP Holloway to Rampton secure hospital. Importantly, the Home Secretary further stipulated that subject to the special restrictions set out in section 49 of the aforementioned Act, there would be no limit on her detention time for her offences.

Despite this, some controversy surrounds this decision with both psychological and legal implications. Firstly, the added complexity of Allitt being in a nursing position as opposed to a parent during her offending series raises questions. Often when making a diagnosis of MSBP the physician will ask whether 'the child receiving unnecessary and harmful or potentially harmful medical care' (Stirling, 2007), referring to the presence of fabricated symptoms and subsequent unnecessary treatment. Examining offence characteristics of Allitt, it is apparent that all of her victims were under her care because they required treatment and had been initially admitted on the basis of genuine illness. It was therefore not the initial fabrication of illness that was a feature of Allitt's modus operandi but instead the medical 'treatment' she provided that was not making the children healthier. Rather her treatment was intentionally making the patients' health worse, seemingly as a result of her desire to receive praise from staff and the victims' relatives upon subsequent health improvements being made. Typically, sufferers of the disorder are considered to target only child victims and research is infrequent that considers manifestations onto older victims (Moreno-Arino & Bayer, 2017). Classifications of the disorder also lack acknowledgement of variations within suffers (Duggan & Gibbon, 2008), something which makes accurate diagnosis in Allitt's case difficult to confidently ascertain.

Closer consideration of the case characteristics displays that, when suspended from her position on the paediatric ward, Allitt gained a position at a nursing home where she was accused of again attempting to murder an elderly woman. Whilst contradicting previous understanding of the MSBP disorder, this may be explained as the result of her no longer

having access to children and as such, the behaviours appear likely to have manifested onto alternatively available victims. Moreno-Arino and Bayer (2017) presented findings that in cases of MSBP, the primary motivation is the attainment of sympathy and attention from health and social care staff, and sometimes the family members of the victims. It is clear from first hand interviews conducted with faculty management where Allitt offended and alternative confirmed accounts (Personal Communication, 2013; Ramsland, 2007), that she did receive the desired attention from staff. Therefore, it appears likely that when no longer receiving the desired response from her traditional victims, vulnerable as a product of their youth and lack of health, she sought further opportunistic situations whereby she would again attain such sympathy. Importantly, recent developments in understanding of MSBP highlight that it is the psychological reward for behaviour, as opposed to external personal gain, that can be considered as the primary motivator (Moreno-Arino & Bayer, 2017), further supporting the aforementioned notion of Allitt's actions.

Whilst Allitt never appears to have wanted any notoriety for committing the crimes, maintaining her innocence throughout her trial and after being found guilty, she appears instead to be driven by the sympathy she obtained from her involvement. Although recent research provides evidence of distinct offender motivation classifications for their crimes, thought to be consistent between differing offence types and rooted in intrinsic narrative justifications (cf. Willmott & Ioannou, 2017), Allitt in fact makes no such justifications of her criminality. Whilst it has not been suggested that there were any other older victims of Allitt, previous literature suggests that due to older individuals having greater medical complexity and low physiological reserve, the risk of death as opposed to younger victims of MSBP, is significantly greater. Accordingly, it is often more difficult to detect foul play that may have occurred (Moreno-Arino & Bayer, 2017). One diagnostic criteria of 'factitious disorder imposed on another' however is that, the 'behaviour is not better explained by another mental disorder, such as, delusional disorder or another psychotic disorder' (American Psychiatric Association, 2013, p.325). This warrants further exploration here as Allitt also appears to exhibit a number of characteristics associated with Borderline personality disorder (BPD).

Within the DSM-V, BPD is characterised as 'a pervasive pattern of instability of interpersonal relationships, self-image, affect, and marked impulsivity, beginning in early adulthood and present across a variety of contexts' (APA, 2013, p.663). The first signs of Allitt's attention seeking behaviour occurred in secondary school where confirmed accounts suggest she would frequently wear plasters, bandages, and plaster casts without medical necessity (Clothier, MacDonald, & Shaw, 1994; Ramsland, 2007). These behaviours were at the time dismissed as trivial and thought to have resulted from her 'clumsiness' (Davies, 1993). Yet at

one point, Allitt is known to have convinced doctors that she had appendicitis which led them to perform unnecessary surgery on her (Davies, 1993). Whilst under the age of 18, even if Allitt's behaviour had alerted medical practitioners, Miller, Muehlenkamp, and Jacobson (2008) suggest that historically, psychiatrists were reluctant to place such a diagnosis on an individual's exhibiting early indicators and argue that such oversights often exacerbate serious problems in the future. This appears somewhat of an accurate account of Allitt's subsequent offences. The combination of her criminality and the unusual incidents known to have occurred, appear to display a pattern of abnormal behaviour and instability, which began early on and were present across multiple situations within her life, conforming to the characteristics of BPD (APA, 2013, p.663).

Problematically, the DSM diagnosis of a factitious disorder has little clinical validity (Kanaan & Wessely, 2010) and the lack of detailed understanding around the condition (cf. Bande & Garcia-Alba, 2008) makes any decision on its presence or absence in the case of Allitt difficult to confidently ascertain - particularly important when considering the Home Secretary direction under section 49 of the Mental Health Act 1983 to detain Allitt indefinitely within a psychiatric facility (Case No: 2004/1058/MTS). The lack of clinical validity may cast doubt on the diagnosis and therefore may suggest the co-occurrence of symptoms with another disorder, such as personality disorder. Some research has in fact shown that Munchausen Syndrome is often accompanied by a personality disorder (Feldman & Ford, 2000), which only amplifies the potential issues around diagnosis and management on the basis of the DSM-V in this case (Bande & Garcia-Alba, 2008). Allitt clearly possesses a number of characteristics that indicate a complex psychopathology and this is something which appears to be best explained through the presence of both factitious disorder and BPD, rather than the existence of one such disorder in isolation. In light of the rarity of female gendered violence which targets victims in this way (Parker & Hefner, 2015), psychopathological accounts of criminality gather further credence.

COMPETING EXPLANATIONS

Although the psychopathological approach to explaining Allitt's case has strengths, such perspectives are often criticised, not least for the notion that they introduce an element of excusing the perpetrators agency in criminal conduct (Debowska & Boduszek, 2016; Debowska, Boduszek & Willmott, 2017; Raine, 2013). The implications of Allitt's supposed diagnosis by Professor Meadows meant that for a long time she has been held in a secure hospital rather than a general population prison (R v Beverly Allitt 1992 [2007] EWHC 2845).

Social Learning Theory (SLT) first proposed by Bandura (1977), suggests that an individual's behaviour is often acquired and learned through a process of observation, imitation and modelling. The assumptions of SLT offer an alternative useful explanation for Allitt's behaviour. As previously stated, growing up Allitt would frequently be seen wearing plasters, bandages and even casts (Clothier, MacDonald, & Shaw, 1994). It is typical during their early years that children, at some point, sustain some form of injury or become ill. As such, through a process of observational learning, Allitt is highly likely to have experienced such incidents and acquired knowledge surrounding typical behaviours and symptoms of illness, subsequently mimicking this behaviour by way of falsifying injuries or illnesses. Whilst the case characteristics examined do not appear to display the presence of a Criminal Social Identity (CSI) (Boduszek & Debowska, 2017; Boduszek, Dhingra, Debowska, 2016; Sherretts et al., 2017; Sherretts & Willmott, 2016), social learning appears to have some influence upon accounting for Allitt's behaviour.

Exploring the relationship between behaviour and consequence further, the principles of operant conditioning (Skinner, 1957) may be applied. Here, reinforcement as a key role in criminal and deviant behaviour has received a lot of attention (Akers & Jensen, 2006). Allitt may have observed and understood the consequences of injury and illness as positive, due to the attention attained which it is agreed was her likely motivation, instead of negative, due to the pain of injury. One likely reason for this may be that many of her injuries were fabricated resulting in minimal pain and discomfort which usually precedes negative reinforcement of behaviours and thus the reinforcement obtained can be considered largely positive causing her to repeat the behaviours. However, whilst there were other occasions where pain would have been present, such as upon convincing doctors to remove her appendix unnecessarily, the greater degree of attention she obtained was likely to outweigh the pain inflicted.

Mobini (2015) suggests that factious disorders and health seeking behaviours may have origins in the learning experience during childhood. It is possible that such origins continued to develop throughout Allitt's childhood and into adolescence and adulthood. By this time it is also likely that such behaviours had become reinforced and learnt such that Allitt would instead be focused on the internal 'positive' consequence of attention gained, not the 'negative' consequences of her behaviour. Akers and Jensen (2006) argue that it is the social interaction in which it is the words and responses of people that provide the setting for reinforcement. Here that is the sympathy and attention displayed by individuals around Allitt that provided a situation whereby deviant behaviour was continually reinforced.

Explaining the transition from self-harm to the desire to harm others however, is not so easily explainable using social learning and operant conditioning principles. Due to the length of time working in the healthcare profession, it is likely that Allitt had at some point, witnessed the attention that staff or family members received when someone in their care was seriously ill and had died. Resultantly, it is plausible that she had replicated this behaviour to receive the same degree of attention. At first Allitt's actions did not cause death, but instead made children ill and subsequently she would make them better. As such, this process provided her with the attention and praise she desired. Through positive reinforcement, this behaviour appears to have continued and at some point, whether initially intentional or unintentional, her actions ultimately caused death. However, instead of this acting as negative reinforcement, the attention she received from those giving sympathy appears to have led to further positive reinforcement and the continuation of such deviant criminal behaviours. Despite being somewhat speculative in nature, a combination of social-environmental influence and psychopathology, therefore offers a more complete explanation of Allitt's crimes; more so than MSBP appears to in isolation.

LEGAL CONSIDERATIONS AND IMPLICATIONS

A notable aspect of the Beverley Allitt case was that despite initially being criminally convicted of Murder contrary to English common law, since 1993 she has remained within Rampton secure hospital. Notably, this is an environment perhaps more favourable to an offender who perpetrated crimes within a hospital environment and who is psychologically thought to relish in the diagnosis of illness both applied to herself and those around her. This in itself warrants further legal consideration of the facts of the case.

Significantly, post-trial the defence employed the services of a Professor Roy Meadows, who at the time was considered to be a leading expert on MSBP. In fact, the same expert testified in many high profile child abuse and child death cases whereby a similar MSBP diagnosis was provided by him. However, a contemporary review of such evidence displays this to be contentious for a number of reasons. Firstly, as previously stated MSBP is not formally recognised as a clinical disorder within dominant mental health classification manuals, such as the DSM-V (APA, 2013). Whilst the Fabricated Induced Illness by Carers (FIIC) is recognised within such manuals, the central definitional issue surrounds whether carers who fabricate illness in children under their care, have the accompanying personality profile required for a MSBP label to be assigned - with many arguing they do not (Hayward-Brown, 2004).

Additionally, examination of the 2007 High Court review of Beverley Allitt's conviction, ordered in light of the need to determine a minimum tariff for incarceration (previously undetermined by the Home Secretary) [2007] EWHC 2845 (QB), further draws into question the expert testimony which contributed to her serving her sentence within a secure hospital rather than a general population prison. Moreover, in September 2004 Beverley Allitt's solicitors instructed a new expert, Professor Bod Peckitt, to review Allitt's medical condition, as well as, Professor Meadow's initial medical assessment. Notably, Professor Peckitt, an experienced consultant forensic psychiatrist, provided a damning report for the High Court. Seriously undermining the veracity of the initial MSBP diagnosis, Professor Peckitt drew the courts attention to the fact that whilst in 1993 Professor Meadows was the leading expert in MSBP, he was not a qualified or trained psychiatrist. Further still, it became apparent that his assessment had also been based merely upon a review of others case notes of Allitt, as opposed to any first-hand interviews conducted with her.

Significantly, within Professor Peckitt's own assessment of Allitt, whilst recognising the presence of MSBP, he alternatively highlighted the importance of narcissistic and BPD features previously not recognised. Alongside such, he testified sadistic expressions of violence towards children were centrally important to accurately understanding the root of her criminality. Accordingly, in contrast to hospitalised confinement, Professor Peckitt made recommendations that Beverley Allitt should be enrolled into a National Offender Management System (NOMS) training program, with a view to be returned to prison as a long term lifer inmate.

Based upon this assessment, the Judge Mr Justice Stanley Burnton, concluded that in his personal view he too felt MSBP should not be treated as a mental disorder under the Mental Health Act 1983 but in fact should be considered a complex set of behaviours and attitudes that derive from a flawed personality structure. This, taken alongside the seriousness of her offences, led to the conclusion that early release provisions referred to in section 269 of the Criminal Justice Act 2003 would apply to Allitt after she had served a period of 30 years imprisonment (less the period she spent on remand and in prison prior to being moved to Rampton Hospital in 1993).

The implications of disputed medical testimony clearly have important consequences within this case and beyond. In light of Professor Meadow's expert testimony surrounding MSBP within this and other cases, now felt to be uneasy at best (see R v Canning [2004] EWCA Crim 01), the Court of Appeal adopted considerations emphasised by the judgement in R v Canning surrounding application within care proceedings. Notably, the court set out:(i) the cause of an

injury or an episode that cannot be explained scientifically should remain equivocal, (ii) recurrence is not in itself probative, (iii) caution is necessary within cases where the medical experts disagree, (iv) the court should always be on guard against the over dogmatic expert or whose reputation is at stake, and (v) the judge in care proceedings must never forget that today's medical certainty may be discharged by the next generation of scientific experts and research (Macur, 2005). All of which provide greater safeguards for assigning the appropriate weight and reliability assessment of expert testimony within future care cases and in particular, those involving an ascribed label of MSBP.

CONCLUSIONS

The current exploration attempts to provide greater insight into the psychological underpinnings and legal implications of female child serial killer Beverly Allitt's criminality. Whilst female perpetrators of such crimes are extremely uncommon and the gendered nature of serial killing is evident within past research (Walters et al., 2015), the rarity of the offence undoubtedly warrants further examination. The psychopathological components of Allitt's actions display the presence of serious and complex pathologies, seemingly rooted in a clinical disorder. However, the infrequency of MSBP as an official diagnosis and lack of scientific understanding around such, results in the accuracy of this as a complete explanation for her crimes remaining unresolved. Nonetheless, thorough examination of confirmed offence characteristics that surround Allitt's criminality and behaviour more generally, appears to suggest that a combination of clinical disorders alongside social-environmental influences may offer a more complete account of her actions. Whilst the presence of MSBP is not contested, it is argued that such a labelled diagnosis should not be considered to explain her criminality in its entirety or restrict attempts to fully understand her criminal trajectory, particularly in light of evidence which appears to support the presence of BPD. Likewise, social and environmental influences also appear to have relevance in accounting for how Allitt's behaviour developed and continued throughout her life. Summing up this notion well, the faculty manager interviewed as part of this exploration suggested, that although Allitt began offending simply to be noticed, the need for "theatrics" developed to such a point that "killing became necessary so that she could ensure she had the attention she craved" (Personal communication, 2013). Therefore whilst the case of Beverley Allitt is undoubtedly complex, it is likely that a multitude of factors played a role in her criminal trajectory, leading to the eventual killings that took place. The present psychological analysis has suggested that there is value in considering competing explanations for Allitt's behaviour beyond the primary explanation that her behaviour was caused by the presence of MSBP as concluded by the

initial 'expert' interpreting her criminality. Only by considering such non-psychiatric contributing factors are professionals able to manage and prevent such atypical violent offending within similar perpetrators of the future, and through such instances the legal implications for future cases able to be developed and understood.

Acknowledgments: Special thanks are given to the faculty manager who worked at the facility where Beverley Allitt was interviewed and kindly gave up his time in order to be interviewed as part of the examination conducted within the present paper.

Disclosure Statement: There are no declarations to be made and no known conflicts of interest. No funding was received for this work. No competing financial interests exist.

REFERENCES

Akers R L, Jensen G F. (2006). The empirical status of social learning theory of crime and deviance: The past, present and future. In Taking stock: The status of criminological theory. F.T. Cullen & J.P. Wright, eds. (New Jersey: Transaction Publishers) pp.37-76.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). (Arlington, VA: American Psychiatric Publishing)

Asher R. (1951) Munchausen's syndrome. Lancet. 1, 339-341

Bandura A. (1977). Social Learning Theory. (Oxford: Prentice Hall)

Bass C, Halligan P. (2014). Factitious disorders and malingering: challenges for clinical assessment and management. Lancet, 383, 1422-1432.

Boduszek D, Debowska A. (2016). Critical evaluation of psychopathy measurement (PCL-R and SRP-III/SF) and recommendations for future research. J Crim Just. 44, 1-12.

Boduszek D, Debowska A. (2017). Further insights into the construct of criminal social identity: validation of a revised measure in a prison population. J Foren Psych Psychol. 18, 1-7.

Boduszek D, Debowska A, Willmott D. (2017a) Latent profile analysis of psychopatic traits among homicide, general violent, property and white-collar offenders. J Crim Just. 51, 17-23.

Boduszek D, Debowska A, Willmott D. (2017b - In Press). Psychopathic Personality Traits Model (PPTM): A new approach to defining psychopathy. In: M. DeLisi (ed) Routledge International Handbook of Psychopathy and Crime. Routledge Taylor & Francis Group.

Boduszek D, Debowska, A, Trotman Jemmott, E, Da Breo H, Willmott, D, Sherretts N. & Jones, A.D. (2017). Victimisation, violence perpetration and attitudes towards violence among boys and girls from Barbados and Grenada. Hudd Uni Press

Boduszek D, Dhingra K, Debowska A. (2016). The integrated psychosocial model of criminal social identity (IPM-CSI). Dev Beh. 37, 1023-1031.

Bools, C, Neale, B, Meadow, R. (1994). Munchausen syndrome by proxy: A study of psychopathology. Child Abuse Neglect. 18, 773-788.

Boyd A S, Ritchie C, Likhari S. (2014). Munchausen syndrome and Munchausen syndrome by proxy in dermatology. J Am Acad Dermatol. 71, 376-381.

Clothier, C, MacDonald, C A, Shaw, D A. (1994). The Allitt Inquiry. Independent Inquiry Relating to Deaths and Injuries on the Children's Ward at Grantham and Kesteven General Hospital during the period February to April 1991. (London: The Stationery Office)

Davies, N. (1993). Murder on ward four. (London: Chatto & Windus Ltd)

Davis, P, McClure, R J, Rolfe, K, et al. (1998). Procedures, placement, and risks of further abuse after Munchausen syndrome by proxy, non-accidental poisoning, and non-accidental suffocation. Arch dis Child. 78, 217-221.

Debowska A, Boduszek D. (2016). Child abuse and neglect profiles and their psychosocial consequences in a large sample of incarcerated males. Child Abuse Neglect. 65, 266-277.

Debowska, A, Boduszek, D, Dhingra, K, et al. (2017). Can we use Hare's Psychopathy model within Forensic and Non-Forensic Populations? Empirical Investigation. Deviant Behav.

Debowska A, Boduszek D, Willmott D. (2017). Psychosocial correlates of attitudes towards male sexual violence in a sample of property crime, financial crime, general violent, and homicide offenders. Sex Abuse-J Res Tr.

Debowska A, Willmott D, Boduszek D, Jones A. (2017). What do we know about Child Abuse and Neglect Patterns of Co-occurrence? A Systematic Review of Profiling Studies and Recommendations for Future Research. Child Abuse Neglect.

Duggan C, Gibbon, S. (2008). Practical assessment of personality disorder. Psychiatr. 7, 99-101.

Feldman, M D, Ford, C V. (2000). Factitious Disorders. In Kaplan and Sadock's comprehensive textbook of psychiatry. B J Sadock V A Sadock, eds. (Philadelphia: Lippincott Williams and Wilkins), pp. 1533-1547.

Haywood-Brown H. (2004). Munchausen syndrome by proxy (MSBP): Some medico-legal issues. Judic Off Bullet. 16.

Jarvis B. (2007). Monsters Inc.: Serial killers and consumer culture. Crime Media Cult. 3, 326-344.

Kanaan R A, Wessely, S. (2010). The origins of factitious disorder. Hist Human Sci. 23, 68-85.

Kamimura A, Nourian M M, Assasnik N, et al. (2016). The use of physical violence against intimate partners by female college students in India. Violence Gender. 4, 11-16.

Macur J. (2005). Factitous Illness By Proxy: Where are we now? Fam Law.

Marks V, Richmond C. (2008) Beverly Allitt: the nurse who killed babies. J Roy Soc Med. 101, 110-115

Miller A L, Muehlenkamp J L, Jacobson C M. (2008). Fact or Fiction: Diagnosing borderline personality disorder in adolescents. Clin Psychol Rev. 28, 969-981.

Mobini S. (2015). Psychology of medically unexplained symptoms: A practical review. Cogent Psychol. 2, 1-10.

Murray J B. (1997). Munchausen Syndrome/ Munchausen Syndrome by proxy. J Psychol. 131, 343-352.

Parker F, Hefner K. (2015). Intersections of race, gender, disadvantage, and violence: Applying intersectionality to the macro-level study of female homicide. Just Quart. 32, 223-254.

Raine A. (2013). The psychopathology of crime: Criminal behavior as a clinical disorder. (Philadelphia: Elsevier)

Ramsland K M. (2007). Inside the Minds of Healthcare Serial Killers: Why They Kill. Westport. (Connecticut: Praeger Publishers)

Rosenberg D A. (1987). Web of deceit: a literature review of Munchausen syndrome by proxy. Child Abuse Neglect. 11, 547-563.

Sheridan M S. (2003). The deceit continues: An updated review of Munchausen syndrome by proxy. Child Abuse Neglect. 27, 431-451.

Sherretts N, Willmott D. (2016). Construct validity and dimensionality of the measure of criminal social identity using data drawn from American, Pakistani, and Polish inmates. J Crim Psychol. 6, 134-143.

Skinner, B.F. (1957). Verbal Learning. (New York: Appleton-Century-Crofts)

Stirling J, Committee on Child Abuse and Neglect. (2007). Beyond Munchausen syndrome by proxy: identification and treatment of child abuse in a medical setting. Paediatr. 119, 1026-1030.

Walters B, Drislane L E, Patrick C J, et al. (2015). Serial murder: Facts and misconceptions. National Courts and Science Institute, Inc.

Willmott D, Ioannou M. (2017). Differentiating English Rioters: An Exploratory Narrative Framework. Howard J Crim Just. 56, 105-124.